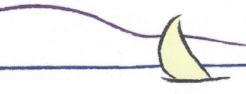
Harbor Physical Therapy & Wellness CLINIC



PO Box 958 Freeland, WA 98249 (360) 331-3969

Patient Information

| Name: | | | | _ DOB: | | |
|--|-------------------------|--|--|------------------------------|-------------------|--|
| Name: | | | MI | | 0.000 | |
| Age: | SSN: | | Contact Phone: | | | |
| Address: | 4 | | | | | |
| 10000001400000000000000000000000000000 | Street / PO Box | | City | State | Zip | |
| Parent/Guardian | (if under age of | 14): | ac meaning a second | | | |
| Emergency Contact: | | | Emergency Ph | Emergency Phone: | | |
| Referring MD Ful | 1 Name: | | | | | |
| Primary Insurance | e Coverage: | | | | | |
| Policy/Claim/ID | #: | - | Group #: | | | |
| Primary Insurance Coverage: Policy/Claim/ID#: Is Patient Subscriber? Y N (If not, please fill out subscriber information below) | | | | | | |
| Name of the Control o | | | | | | |
| Secondary Insura | nce Coverage: _ | A ANNAL AL AL AL AND | | | - | |
| Policy/Claim/ID #: Group #: Group #: Is Patient Subscriber? \(\subscriber \) \(\subs | | | | | | |
| Is Patient | Subscriber? \square 1 | $V \sqcup N$ (If not, p | lease fill out subscriber ir | iformation below) | | |
| Carles suite ou Info (| C + l + l - | au national Mama | | | | |
| | | | :Pelationshir | | | |
| DOB: SSN: Relationship to Paitent:_ Address: Employer: | | | | | | |
| Address. | | | | | | |
| Where did this injury happen? | | 1? | Date of Injury/S | Surgery: | | |
| $(If a_i)$ | oplicable) | | Affected Body I | Part. | | |
| work | auto acciden | nt | | Side: R L Bi | | |
| recreation | home | | Next MD appt | | | |
| | | Patient Cor | ısent & Release | | | |
| INSURANCE: Plan and coverage will determine the amount your insurance company pays us. We require the all co-pays and current | | | | | | |
| balances be paid at the time of service. Any other payment plans will need to be made in advance. By signing below, I verify that I have read and agree to Harbor Physical Therapy's financial policies and privacy practices. | | | | | | |
| RELEASE OF BENEFITS AND INFORMATION: I authorize Harbor Physical Therapy & Wellness Clinic to bill my current insurance. I | | | | | | |
| authorize my insurance benefits to be paid directly to Harbor Physical Therapy & Wellness Clinic. I understand that I am financially responsible for any balance due. I authorize the release of any claim related medical information to determine benefits. I understand that any | | | | | | |
| information deemed to | be fradulent with res | pect to my insurance in , PT and associates of | negretated medical information information will result in my in Harbor Physical Therapy & they deem necessary. | responsibility to pay all ch | arges in full. By | |
| Patient Signature | | | | Date: | | |
| | | | | | | |